Health Reimbursement Arrangement (HRA) Premium Reimbursement

(Do not Fax or Mail this Instruction Page)

SELECTQUOTE SENIOR INSURANCE SERVICES Powered By Acclaris

This form is used to request reimbursement for health care premium expenses only.

Submit your claim using this form.

Step 1: Complete the form

- *Please print in capital letters, with the letters centered in the boxes as shown:*

A	B	C	D		1	2	3	4

- *Complete a separate line for each individual expense.*

Step 2: Attach Supporting Documentation

- *See the "Types of Supporting Documentation" box on the right for a description of what is considered acceptable*
- *Do not send original receipts or original supporting documentation*
- *Photocopy your receipts and /or other supporting documentation onto a white, letter-sized sheet of paper*

Step 3: Certify

- *Read the Certification and then sign and date the form*

Step 4: Submit

- **FAX** *the form and supporting documentation to 813-387-0737*
- *Make sure that you fax the form and supporting documentation together. The form should be the first page in the stack of pages that you fax.*
- *Do not fax this instruction page or your own fax cover-sheet*
- *Alternatively, you may also mail your claims to:*

  Spending Account Processing
  PO Box 25172
  Lehigh Valley, PA 18002-5172

Remember

- *Keep a copy of the form and all original receipts for your records*

Direct Deposit!

Why wait for a check? Expedite your payments by signing up for direct deposit today at www.bsa.selectquotebenefits.com. (Go to the HRA link on the top of the page.)

NOTE: *Once your banking information has been entered it may take up to 10 days to verify with your bank. During this time any payments will be sent via check until your banking information has been successfully validated.*

If you have any questions about your account status, please create a Help Ticket at www.bsa.selectquotebenefits.com (HRA tab) 24 hours a day, 7 days a week, or reach the Acclaris Reimbursement Center toll-free at 866-479-8317 (Option 2) Monday - Friday during regular business hours.

Type of Supporting Documentation

- Copy of your premium invoice
- Must show:
  - Date of service or purchase
  - Amount (paid by you)
  - Name of person or organization providing the service or product
- Cancelled checks or credit card receipts are acceptable evidence

Please Do

- For multiple expenses on one receipt, use one line to show a total of such expenses
- For different expense types, or expenses that are on different receipts, use one line per expense/receipt
- Use additional copies of Page 2 if your expenses exceed the number of lines available
- Be sure to print legibly, use ink or type, and use capital letters

Please Do Not

- Fill out the form using red or blue ink
- Highlight receipts or any part of the form
- Send original receipts
- Photocopy the form
- Staple copied receipts to the form
- Write outside the boxes provided
- Submit the same claim more than once
- Fax or mail this Instruction Page

Health Reimbursement Arrangement (HRA) Premium Reimbursement

FAX TO: 813.387.0737

or Mail to: Spending Account Processing, PO Box 25172, Lehigh Valley, PA 18002-5172

SECTION 1: YOUR INFORMATION (Use only CAPITAL LETTERS)

PARTICIPANT ID / SSN

EMPLOYER or GROUP NAME

PARTICIPANT LAST NAME

PARTICIPANT FIRST NAME

PARTICIPANT EMAIL

DAYTIME PHONE # (AREA CODE FIRST - NO DASHES)

SECTION 2: PREMIUM REIMBURSEMENTS (One Time only or Recurring)

PREMIUM

PREMIUMS PAID TO

DATES OF SERVICE FROM (MMDDYY)

TO (MMDDYY)

CHECK BOX IF RECURRING

FREQUENCY: MONTHLY, QUARTERLY, ANNUAL OR ONE-TIME

PREMIUM PAYMENT AMOUNT

$.

COVERAGE FOR (NAME & RELATIONSHIP)

PREMIUM

PREMIUMS PAID TO

DATES OF SERVICE FROM (MMDDYY)

TO (MMDDYY)

CHECK BOX IF RECURRING

FREQUENCY: MONTHLY, QUARTERLY, ANNUAL OR ONE-TIME

PREMIUM PAYMENT AMOUNT

$.

COVERAGE FOR (NAME & RELATIONSHIP)

PREMIUM

PREMIUMS PAID TO

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CHECK BOX IF RECURRING

FREQUENCY: MONTHLY, QUARTERLY, ANNUAL OR ONE-TIME

PREMIUM PAYMENT AMOUNT

$.

COVERAGE FOR (NAME & RELATIONSHIP)

SECTION 3: SELF CERTIFICATION

I certify that all expenses for which reimbursement or payment is requested by submission of this form have been or will be incurred during a period while I was covered under the program, and that these expenses have not been reimbursed or are not reimbursable under any other plan/program. If future expenses are being submitted, I understand that it is my responsibility to notify the Administrator of any changes to my expenses, like a change in insurance coverage or a change in premium, to ensure that I only receive reimbursements for valid expenses. I fully understand that I alone am responsible for the sufficiency, accuracy and truthfulness of all information relating to this request and that I am solely liable for payment of all related taxes including federal, state and/or city income tax and penalties on amounts paid which relate to such expense. A copy or electronic facsimile of this form and all supporting documentation shall be deemed as valid as the original. I agree to abide by the terms of the program and have read the information on this form. Annual certification will be required.

PARTICIPANT SIGNATURE:* _____ DATE: _____

DO NOT SEND ORIGINAL RECEIPTS
HEALTH REIMBURSEMENT ARRANGEMENT